

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

18170

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis, Mo.**

(No. **City of St. Louis**)

File No.

Registered No. **3472**

St.

Ward)

2. FULL NAME

(a) Residence. (No. **2845 Howard**)

(Usual place of abode)

20 Ward.

Length of residence in city or town where death occurred **Life**

mos.

da.

How long in U.S., if of foreign birth?

yrs.

mos.

da.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF

Unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

not known

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

abt. 38

0

0

0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

75

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

10. NAME OF FATHER

Gus Williams

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

12. MAIDEN NAME OF MOTHER

Clara Jones

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

La.

14.

INFORMANT

(Address)

City Hospital #2

15.

FILED

APR 10 1927

Male 6 Starkey

REGISTERED

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

April 6 1927

17.

I HEREBY CERTIFY, That I attended deceased from **Feb 17**

17, 19**27**, **April 6**, 19**27**, that I last saw him alive on **April 6**, 19**27**, and that death occurred, on the date stated above, at **18 a** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis

121

921

CONTRIBUTORY (SECONDARY)

Chronic nephritis

Indefinite

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF BIRTH

DID AN OPERATION PRECEDE DEATH? **No** DATE OF

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

19 (Address)

*State the DISEASE CAUSING DEATH in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Jefferson Barricks Mo

April 11 1927

20. UNDERTAKER

Williams

ADDRESS

3232 Pine

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECORD WITH OUPDING INK—THIS IS A PERMANENT RECORD

